DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0093	A. BUILDING: _____ B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKNOLL AL	1 OAKNOLL COURT IOWA CITY, IA 52246

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 20 Number of tenants with cognitive impairment: 13 Total census: 33 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow its policies and procedures related to the medication pass observed. This pertained to 6 of 7 tenants observed who received medications administered during the medication pass (Tenants #2, #5, #6, #8, #9 and #10). Findings follow: 1. When observed on 3/24/25 starting at approximately 4:17 p.m. Staff A administered medications to seven tenants, Tenants #2, #5, #6, #7, #8, #9 and #10. The medications were kept in	A 150	Please accept this as Oaknoll Retirement Residence -- Assisted Living credible allegation of compliance.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 150	Continued From page 1 a cart which was located in the medication room. Staff A first administered medications to Tenant #5. He received an oral medication and eye drops. She donned gloves while in the medication room then touched the door handle of the medication room when exiting, which was a contaminated surface. Tenant #5 was in the hallway outside of medication room. The drops were instilled in both eyes (Staff A was not observed touching his eye lids). A change of gloves was not observed prior to the administration of the eye drops, after touching a contaminated surface. She next administered oral medications to Tenant #6. When preparing Tenant #6's medications from the bubblepack to the medication cup, one pill dropped onto the top of the medication cart. There was not a barrier observed on the top of the medication cart. Staff A picked up the pill with a bare hand and put it into the medication cup. Staff A took the medications to Tenant #6 and she consumed them. Staff A next administered medications to Tenant #7 (no concerns were observed) and then administered medications to Tenant #8. When preparing Tenant #8's medications from the bubblepack to the medication cup, one pill dropped onto the top of the medication cart. There was not a barrier observed on the top of the medication cart. Staff A picked up the pill with a gloved hand and put it into the medication cup. Staff A took the medications to Tenant #8's apartment. Staff confirmed Tenant #8 took the medications. Staff A then assisted with the administration of a nasal spray for Tenant #2. She left the medication	A 150		3/26/25
		A 150	Nurse was re-educated on hand hygiene and gloves policy including when to appropriately don prior to administration of a treatment. Nurse verbalized understanding and signed off on policy review. Reviewed eye drop protocol, including proper administration of eye drops with clean gloves and pulling down lower lid. Med pass audits put in place once a month x 3 months.	
		A 150		3/26/25
			Nurse was re-educated on hand hygiene and glove policy in addition to sanitation protocol. re-education provided regarding working surface should be sanitized or barrier should be placed down before preparing medications. Nurse was re-educated that if a medication becomes contaminated, it should be disposed of and replacement should be used. Policies reviewed and signed. Med pass audits put in place once a month x 3 months.	
		A 150		3/26/25
			Nurse was re-educated on hand hygiene and glove policy in addition to sanitation protocol. re-education provided regarding working surface should be sanitized or barrier should be placed down before preparing medications. Nurse was re-educated that if a medication becomes contaminated, it should be disposed of and replacement should be used. Policies reviewed and signed. Med pass audits put in place once a month x 3 months.	

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A 150	Continued From page 2 room and took gloves with her. She donned the gloves in the hallway on the way to Tenant #2's apartment. She touched Tenant #2's apartment door handle with a gloved hand when entering the apartment, which was a contaminated surface. No glove change was observed after touching the contaminated surface. She handed Tenant #2 the nasal spray and Tenant #2 self-administered the nasal spray. Tenant #2 handed the nasal spray back to Staff A. Staff A next administered medications to Tenant #9. When preparing Tenant #9's medications from the bubblepack to the medication cup, one pill dropped onto the top of the medication cart. There was not a barrier observed on the top of the medication cart. Staff A picked up the pill with a gloved hand and put it into the medication cup. She took the medications to Tenant #9 and he consumed the medications. Staff A then administered medications to Tenant #10. She administered oral medications, took a blood glucose reading via a continuous glucometer and assisted with insulin administration for Tenant #10 in his apartment. She dialed up the insulin pen to the ordered number of scheduled units and wiped his arm with an alcohol wipe. She handed Tenant #10 the insulin pen and he injected the insulin. She discarded the needle into the sharps container. Staff A was not observed wearing gloves when she assisted with the insulin. 2. Review of Staff A's training documents indicated Staff A was a registered nurse (RN) and had an RN Orientation/Delegation document on 1/14/25. That training included a sign off on medication administration/set up.	A 150 A 150 A 150 A 150	Nurse was re-educated on hand hygiene and gloves policy including when to appropriately don prior to administration of a treatment. Nurse verbalized understanding and signed off on policy review. Reviewed nasal spray protocol. Med pass audits put in place once a month x 3 months. Nurse was re-educated on hand hygiene and glove policy in addition to sanitation protocol. re-education provided regarding working surface should be sanitized or barrier should be placed down before preparing medications. Nurse was re-educated that if a medication becomes contaminated, it should be disposed of and replacement should be used. Policies reviewed and signed. Med pass audits put in place once a month x 3 months. Nurse was re-educated on hand hygiene policy, glove policy, insulin pen policy, PPE and biohazard waste policy. Verbalized understanding for when to don gloves. Policies reviewed and signed. Med pass audits put in place once a month x 3 months.	3/26/25 3/26/25 3/26/25

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A 150	Continued From page 3 3. On 3/25/25 review of policies and curriculums revealed the following: - the Insulin Pen policy and procedure indicated for staff to gather supplies, complete hand hygiene and don gloves. After the insulin was administered staff were to remove the needle from the pen and place into the sharps container. It indicated to put the cover back on the pen, store back in the medication cart, doff gloves and complete hand hygiene. - The curriculum for the administration of eye drops indicated to complete hand hygiene, don gloves, pull down the lower lid and instill the drops in the lower lid. - The curriculum for the administration of oral medications indicated to complete hand hygiene and sanitize the workspace prior to administration. It then indicated to read the Medication Administration Record (MAR), prepare any needed supplies, complete hand hygiene again and don gloves if touching any medication. - The Medication Administration policy and procedure indicated to remove medication from the source (bubblepack) and to ensure care not to touch with a bare hand. - The curriculum for intranasal medications indicated to complete hand hygiene and don gloves prior to the administration of the nasal spray. 4. When interviewed on 3/24/25 at 10:24 a.m. the Assisted Living Manager (ALM) confirmed all MARs and policies and procedures requested were provided. She said Staff A was a licensed professional and worked as a floor nurse. The Assisted Living Manager (ALM) and Staff B (RN) had gone over processes and system set up with her. Staff B had also watched Staff A complete a medication pass and Staff A had received training on it. Additionally, Staff A observed and received	A 150	Amber Jedlicka, LNHA Director of Health Services 4/15/2025	

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A 150	Continued From page 4 training on administering medications from another nurse for a week. She said Staff A had six weeks of training. She confirmed Staff A did not have any medication errors. The ALM said she expected staff to don gloves for the administration of eye drops and expected a change of gloves if a door handle was touched with gloved hands. Staff were to pull down the lower eye lid with administration of the eye drops. Regarding a barrier on the medication cart, she said staff should be able to punch the medications into the cup (from the bubblepack) and if that could not be done, staff would need to sanitize or put down a barrier. She confirmed staff were not to touch a pill with a bare hand. If the pill was contaminated it would need to be thrown away and a spare pill could be used. She confirmed staff were to wear gloves before and after handing a tenant a nasal spray. She also confirmed if a tenant self-administered insulin (pen) staff were to wear gloves when handling the pen and disposing of the needle.	A 150		